system, just as it is not present in the Resource-based Relative Value Scale.

I am sorry that the authors did not have a comment about the bogus nature of this method of determining reimbursement. The method is actually a cost-containment mechanism that is being used arbitrarily by the government to control reimbursement to physicians. I think the authors do the practice of medicine and the public a disservice by tacitly agreeing with this concept by their thorough investigation. Stepping outside of the box and commenting on the fundamental validity of this system would have been extremely useful for everyone.

James P. Weaver, MD

Central Carolina Cardiovascular and Thoracic Surgical Associates, P.A.
Durham, N.C.

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Reply

To the Editors:

Dr. Weaver's letter is interesting and provocative. He suggests that participation in the Resource-based Relative Value Scale 5-year review implies validation of process, and he concludes that we have done the practice of medicine and the public a disservice through tacit approval. Indeed, we did not use our manuscript to condemn process. Perhaps that was a missed opportunity, but in fact, by working within the admittedly flawed process, vascular surgeons convinced the Specialty Society Relative Value Update Committee and the Health Care Financing Administration (HCFA) that our work values desperately deserved upward adjustment. From that perspective, the greater error may have been submission of just a few rather than all 200 vascular surgery codes for reconsideration during the 5-year review.

Nevertheless, validity of process is terribly important, and value to the consumer is not an identifiable component of the Resource-based Relative Value Scale. Both concepts deserve scrutiny in light of the upcoming resource-based practice expense program, which is due to begin January 1, 1999. The HCFA will shift billions of dollars in annual payments from procedural to cognitive disciplines on the basis of faulty data, dubious accounting methods, and a firm but entirely unsubstantiated conviction that after 6 years of payment reductions, surgeons are still overpaid by Medicare. In this, Dr. Weaver's claim of bogus methodology is most correct. The Government Relations Committee of the Joint Council sent two detailed and highly critical comment letters to the HCFA in 1997 decrying invalidity of the practice expense relative value process. (Copies are available from the Society offices in Manchester, Mass.) In addition, our position has been voiced at several HCFA meetings on practice expense during the past 24 months. Regardless, the HCFA's apparent driver remains manipulation of process to achieve a revenue-shifting goal rather than fairness in distribution of a limited pot of Medicare funds.

In May 1998, the proposed Medicare Fee Schedule for 1999 will be published in the Federal Register. Every surgeon will have 60 days to tell the HCFA their thoughts on process validity and bottom-line result. Those surgeons who believe the upcoming reduction in practice expense revenue will threaten their ability to stay in business should share those concerns with their appropriate congressional delegates. The news may surprise them.

So, where is the value to the consumer in all of this? Why has the consumer remained silent? Will shrinking Medicare reimbursement create a price-point below which access to high-quality vascular surgical services will disappear? Will consumers actually know when that happens? Resource-based practice expense may offer an opportunity to test Dr. Weaver's hypothesis that value to the consumer is a functional paradigm in American medicine.

Robert M. Zwolak, MD, PhD

Dartmouth-Hitchcock Medical Center
Lebanon, N.H.

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